

## Please Read The Instructions Before Filling Out This Form.

Please PRINT CLEARLY using blue

## Enrollment and Change Form Please mail to: BCBS, P.O. Box 9145, North Quincy, MA 02171-9145

Blue Cross Blue Shield of Licensee of the Blue Cros	Massachusetts is an Indepe s and Blue Shield Association	ndent on	or b	lack ink to	o avoid cov	erage delay.									
1. To Be Fill	ed Out by You	Employe	Т												
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Current BCBS ID	Number, if any	Reques	ted Effectiv	e Date	Dat	te of Hire			Current De	ntal Group #	E	ental G	Group # Transfe	erring To	
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Type of Transac		g, please see ir digit terminatio		or   Kem	ıarks: (i.e., o	qualifying e	vent for a ne	ew add, chang	ge to family.	or further instructi	on)				
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are you	Blue	1	Blue Choice New England Other (Write Name of Plan)					Individual		Individual					
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Please check if you	are using separate for	ms for addition	nal depende	nt childre:	n. 🗌				Total # of I	Dependents:		_			
5. Select Pers	onal Savings A	ccount (if	applicab	le)											
☐ HSA	Start Date		End D					FSA GC	OAL AMOU	JNTS: (Please see i	nstructions	for max	kimum limits		
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FSA - Dep.	Start Date		End D				Dependen	r Care \$:							
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Employee's Signatu				Date	-		T7 . 1.	er's Signatur				Date			